



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058

CLAIM FOR COMPENSATION

DIVISION INJURY NUMBER (If known)
17-043628

NOTE: This form must be completed in its entirety and must be typed or hand printed in black ink.

SUBMIT AN ORIGINAL AND THREE COPIES.



ORIGINAL
CLAIM



AMENDED
CLAIM



SECOND INJURY
FUND ONLY

Please read instructions before completing this form.

ITEM NUMBER(S) AMENDED

EMPLOYEE INFORMATION

1. INJURED EMPLOYEE'S NAME LAST Green		FIRST Milton		INITIAL OR MIDDLE NAME	1A. MAILING ADDRESS (ALSO INCLUDE STREET ADDRESS) [REDACTED]
1B. CITY St. Louis	1C. STATE MO	1D. ZIP CODE 63138	2. SOCIAL SECURITY NO. [REDACTED]	3. DATE OF ACCIDENT OR OCCUPATIONAL DISEASE 6/21/17	
4. AVERAGE WEEKLY WAGE \$1300.00		5. TIME OF ACCIDENT <input type="checkbox"/> A.M. _____ <input type="checkbox"/> P.M. _____		6. PLACE OF ACCIDENT (City, County, State, Zip) St. Louis, MO	
7. PART(S) OF BODY INJURED Psychiatric/psychological injury, right arm, right upper extremity					
8. DESCRIBE WHAT THE EMPLOYEE WAS DOING AND HOW THE INJURY OCCURRED. Employee was shot by another police officer and was injured					

EMPLOYER INFORMATION -- If additional employers need to be listed or if you need more space, attach additional sheets.

9. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED. THIS IS THE EMPLOYER IN WHOSE EMPLOYMENT THE INJURY OR OCCUPATIONAL DISEASE OCCURRED. FOR SECOND JOB WAGE LOSS BENEFITS LIST EMPLOYER SEPARATELY IN BOX 10.			
EMPLOYER A:		MAILING ADDRESS	
City of St. Louis		1200 Market Street, Room 314	
CITY St. Louis		STATE MO	ZIP CODE 63103-2805
EMPLOYER B:		MAILING ADDRESS	
CITY		STATE	ZIP CODE
EMPLOYER C:		MAILING ADDRESS	
CITY		STATE	ZIP CODE

10. ADDITIONAL STATEMENTS

Employee is entitled to medical care related to the injury of 6/21/17
Employee is in need of and entitled to additional medical treatment for the injury of 6/21/17
Employee has suffered enhanced disability above and beyond the standard PPD due to the synergistic effects of his combined injuries

DIVISION USE ONLY

REC'D DWC SL APR - 1 2019

DATE STAMP

BE SURE TO COMPLETE NEXT PAGE.

SECOND INJURY FUND CLAIM: IF YOU ARE NOT FILING A CLAIM AGAINST THE SECOND INJURY FUND, PLEASE PROCEED TO BOX 13.

11. ONLY CHECK APPROPRIATE BOX(ES) IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR ANY OF THE FOLLOWING:

☐ PERMANENT PARTIAL DISABILITY

☐ UNINSURED EMPLOYER – MEDICAL AID/DEATH BENEFITS

☐ PERMANENT TOTAL DISABILITY

☐ SECOND JOB WAGE LOSS

11A. IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND BASED UPON A PRE-EXISTING DISABILITY, YOU NEED TO PROVIDE THE FOLLOWING INFORMATION, IF AVAILABLE:

DATE OF PREVIOUS
INJURY/DISEASE

PART(S) OF BODY AFFECTED BY
PREVIOUS INJURY/DISEASE

SECOND JOB WAGE LOSS:

12. IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR SECOND JOB WAGE LOSS, PLEASE PROVIDE THE EMPLOYER NAME, MAILING ADDRESS, CITY, STATE, ZIP CODE, AND COUNTY FOR SECOND JOB WAGE LOSS IN BOX 10.

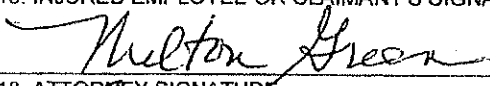
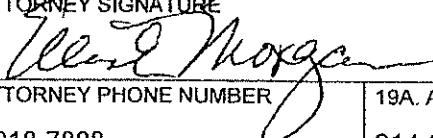
13. DID INJURY RESULT IN DEATH? ☐ YES ☒ NO 13A. DATE OF DEATH ____/____/____

IF DEATH OCCURRED, EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OTHER PERSONS DEPENDENT ON EMPLOYEE).

IF YOU NEED TO LIST DEPENDENTS IN ADDITION TO THESE LISTED BELOW, PLEASE ATTACH A SEPARATE SHEET.

14. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14A. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14B. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED IN THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY (OR DEATH) OF THE EMPLOYEE BY ACCIDENT ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

15. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE 		16. EMPLOYEE/CLAIMANT TELEPHONE NO. 661	17. DATE 3/27/19
18. ATTORNEY SIGNATURE 		18A. ATTORNEY NAME (type or print) Ellen E. Morgan	18B. BAR NUMBER 32218
19. ATTORNEY PHONE NUMBER 314-918-7888	19A. ATTORNEY FAX NUMBER 314-918-8010	19B. ATTORNEY E-MAIL ADDRESS (optional) ellen@ellenmorgan.com	
20. ATTORNEY MAILING ADDRESS 9804 Manchester, Suite D	20A. CITY St Louis	20B. STATE MO	20C. ZIP CODE 63119

LINES 15 & 18 MUST BE SIGNED IN BLACK INK – NOT TYPED.



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

P.O. BOX 58
JEFFERSON CITY
MISSOURI 65102-0058

ANSWER TO CLAIM FOR COMPENSATION

Injury Number
17-043628

DO NOT FILL IN

Rec. Ack. Form >
County >
Place of Hearing >
Checked By >

NOTE: To be sent to the Division at Jefferson City, Missouri, within thirty (30) days of receipt of copy of claim for compensation. Send one copy for the Division, one copy for each claimant, and one copy for each claimant's attorney.

STATE FACTS AND NOT CONCLUSIONS

1. Claimant

MILTON GREEN

Social Security No.

Address

State

Zip Code

MO

63138

2. Name of Employer

CITY OF ST. LOUIS

Address

1200 MARKET ST

State

Zip Code

MO

63103

3. Name of Insurer

SELF-INSURED- CCMSI, TPA

Address

133 S. 11TH ST., STE. 430, ST. LOUIS

State

Zip Code

MO

63102

4. Injured Employee

MILTON GREEN

5. Date of Accident

6/21/17

Place (City)

ST. LOUIS

State

Zip Code

MO

63102

7. All of the statements in the Claim for Compensation are admitted except the following:

Here should be separately set forth the question number of each disputed statement in the Claim for Compensation, the reason why disputed, and the facts in regard thereto. Also any other facts tending to defeat the claim.

Comes now employer and self-insurer and for its answer to Claim for Compensation, admit the employment, that the parties were working under and subject to the Missouri Workers' Compensation Law, that the employee sustained an accidental injury.

For further Answer to Claim for Compensation, employer and self-insurer deny each and every other allegation contained in said claim for compensation

19. Dated

4/16/19

20. Employer's Signature

22. Insurer's Signature

21. By

THOMAS GOEDEL

23. By

24. Attorney Signature

25. Bar Number

42520

26. Telephone Number

314-622-4708

27. Fax Number

314-231-7041

28. Attorney Address

133 S. 11TH STREET, STE. 430

29. City

ST. LOUIS

30. State

MO

31. Zip Code

63102

If additional space is needed, use reverse side.